

many non-consultant grades will be expected to pass it as part of higher training in the specialty in the United Kingdom. It would be interesting to have some figures on the number of candidates anticipated in the near future and how this will affect the examination mechanism.

The Apothecaries Diploma Board rejected viva voce examinations some time ago as being prone to bias. This is consistent with much current research on examination techniques.¹ Oral examinations are regarded as being inherently biased and of poor inter-examiner reliability. How much, however, is this also a candidate number related phenomenon? With courses for small numbers, such as the Diploma in Venereology and Genitourinary Medicine of Liverpool University, we find the viva a key mechanism to discriminate between candidates precisely because the examiner can adjust the level of difficulty of questions to the ability of each candidate. The viva is a good instrument to measure clinical thinking, ability to take a sexual history, and counselling. Role play need not be uniquely the province of actors. The viva is particularly useful for borderline candidates—for example, those who are disadvantaged in essays which are notoriously dependent on proficiency in English (not to mention handwriting!). In order to reduce interexaminer variation inherent in the viva, all candidates for the Liverpool Diploma are viva'd independently by both sets of (two) examiners. Clearly, this would be extremely cumbersome and time consuming for the current and anticipated numbers taking the Apothecaries Diploma.

The venerable Apothecaries' Hall is apparently "unsuitable" for projecting slides a convenient way of basing a clinical skills/data interpretation type examination for a large number of candidates—for example, MRCP Part 2 and many other postgraduate medical examinations. Will the examiners of the Apothecaries Diploma have to begin to think of more appropriate premises for their examination?

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Detection of chlamydia on meatal swabs

EDITOR,—The advent of ligase chain reaction (LCR) and other DNA technologies and their greater sensitivity¹ has allowed the possibility of taking samples other than from the urethra in men, including urine samples.²⁻⁵

Although urine samples have the advantage of being collected non-invasively, the sensitivity of LCR tests on such samples is less than for urethral samples.² This may be due to the presence of inhibitors in urine.⁶ The reduced sensitivity on urine samples may be unacceptable, particularly if testing populations with a high prevalence of chlamydia infection. Furthermore processing of urine samples is more laborious.

It is currently recommended that specimens for the detection of genital *Chlamydia trachomatis* infection by LCR are taken 2–4 cm from the urethral orifice and the swab rotated for 3.5 seconds.⁷ Many men are unable to tolerate this. It is often painful and may discourage patients from seeking medical attention.

A pilot study was conducted to compare the sensitivity of LCR testing for genital chlamydial infection in men, taken from the meatus itself against the standard technique.

All male patients attending the GUM clinic over a 3 month period were included in the study if they had symptoms or signs compatible with chlamydia, or if a contact of a known case of chlamydia. A swab was taken from the urethra in the standard fashion. A second swab was taken from the meatus. After the sixth week of the study the order of the first and second swabs was changed, in order to evaluate any bias related to the order of the swabs. Specimens were processed using Abbott Laboratories LCx Chlamydia and handled according to the manufacturer's guidelines.

Twenty five patients were asked to evaluate the swabs and to state which swab caused least discomfort or if there was no difference between them. A total of 208 men were recruited to the study. The overall prevalence of genital chlamydia infection in our population was 25% (52/208). A confirmed diagnosis was made if both of the samples performed from the same man were positive for chlamydia, or if one sample was positive together with an equivocal result. There were no false positive tests using these criteria giving all methods a specificity of 100%.

There was no significant difference in detection rates between the subgroups where the order of swabs was changed.

There was no significant difference in the sensitivity of samples taken from the meatus (100%) or from deep within the urethra (96.2%). Of the 25 men questioned two (8%) felt that the meatal swab caused more discomfort; 19 (76%) had a strong preference for the meatal technique. Only four men (16%) stated the swabs were similar in terms of discomfort.

A meatal swab for the detection of chlamydia is more acceptable to patients and has a similar sensitivity to the traditional technique of urethral sampling.

Urine samples, although non-invasive, are less likely to yield a positive diagnosis compared to urethral/meatal swabs and require extra processing by laboratories.

In a high prevalence setting (such as a sexual health clinic), the meatal technique provides a specific, highly sensitive, and well tolerated sampling method for the detection of chlamydia infection in men.

Further studies to confirm our findings in symptomatic, and asymptomatic, chlamydia infection are needed before introducing this technique as routine clinical practice.

Contributors: HL, principal investigator and author; SMM, investigator and edited final draft; JLD, data collection and obtained clinical specimens; MSS, investigator and processed specimens.

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HIV positive and negative homosexual men have adopted different strategies for reducing the risk of HIV transmission

EDITOR,—To reduce the risk of HIV transmission, some homosexual men have adopted a strategy whereby they only have unprotected anal intercourse (UAI) with a person of the same HIV status (known as "concordant UAI").¹ In London, homosexual men in a relationship are more likely to know the HIV status of their UAI partner than men not in a relationship² and so establish concordance. However, this was not examined for HIV positive and negative men separately. A survey conducted in January–February 2000 among homosexual/bisexual men attending one of six gyms in central London, as part of an ongoing behavioural surveillance programme,^{2,3} has allowed risk reduction strategies to be considered by HIV status. A total of 792 homosexual men (median age 35 years) completed a confidential questionnaire (estimated response rate 50–60%^{2,3}); 126 (16.0%) were HIV positive, 477 (60.2%) HIV negative, while 169 (21.3%) had never had an HIV test (data missing for 20 men). Just over half the men (55.2%) said they were currently in a relationship with another man; this did not differ significantly by HIV status ($p=0.1$).

Our analysis focused on how sexual risk behaviour varied both by HIV as well as by relationship status. For HIV negative and positive men, UAI was classified as either concordant (UAI with a partner of the same HIV status) or non-concordant (UAI with a partner of unknown or discordant HIV status). Men reporting more than one UAI partner were classified as concordant only if all UAI partners were of the same HIV status as themselves. Men also indicated whether they had had UAI with a main partner only, casual partner(s), or both. One third of all men (32.9%, 259) reported UAI in the previous 3 months; HIV positive men 42.1% (53/126), HIV negative 34.7% (165/475, data missing for two men) ($p=0.1$). Overall, concordant UAI was reported by 18.7% (89) of HIV negative and 21.4% (27) of HIV positive men ($p=0.4$). For HIV negative men, concordant UAI was predominantly reported by those in a relationship and rarely by men who were not (28.6% v 5.0%, $p<0.001$) (table 1). Concordant UAI was usually with a main partner alone. By way of comparison, HIV positive men were just as likely to report

Table 1 Unprotected anal intercourse (UAI) in the previous 3 months

Type of partner for UAI	HIV negative men (n=477*)						HIV positive men (n=126)					
	Main only			Casual†			Main only			Casual†		
	%	No		%	No	%	%	No		%	No	%
Men in a relationship reporting												
Concordant UAI	27.1	(75)		1.5	(4)	28.6	(79)	11.1	(7)	22.2	(14)	22.2
Non-concordant UAI‡	8.0	(22)		6.5	(18)	14.5	(40)	3.2	(2)	19.0	(12)	22.2
Total	35.1	(97)		8.0	(22)	43.1	(119)	14.3	(9)	30.1	(19)	44.4
Men not in a relationship reporting												
Concordant UAI	2.5	(5)		2.5	(5)	5.0	(10)	1.6	(1)	19.0	(12)	20.6
Non-concordant UAI‡	1.5	(3)		16.1	(32)	17.6	(35)	0.0	(0)	19.0	(12)	19.0
Total	4.0	(8)		18.6	(37)	22.6	(45)	1.6	(1)	38.1	(24)	39.7

*Data on UAI or relationship status missing for two HIV negative men.

†Men reporting casual partners only or main and casual partners. Most men reported casual partners only.

‡Men reporting UAI with a partner of unknown or discordant HIV status. Non-concordant UAI was predominantly with a partner of unknown HIV status.

concordant UAI whether they were in a relationship or not (22.2% *v* 20.6%, *p*=0.9), often with a casual rather than main partner. The observation that HIV negative men were more likely to report concordant UAI in the context of a relationship while HIV positive men were just as likely to report concordant UAI whether they were in a relationship or not was confirmed in a multivariate model. With HIV status and relationship as independent variables and concordant UAI as the dependent variable, the interaction between HIV status and relationship was highly significant (*p*=0.001).

Seroconcordance among negative men can only be established with confidence if both men test for HIV together. For this reason it is difficult for HIV negative men to establish concordance with a casual partner. On the other hand, HIV positive men can establish concordance, be it with a casual or regular partner, simply by mutual disclosure. This requires no confirmatory test. Although seroconcordant UAI among positive men carries no risk of HIV transmission to an uninfected person, it raises the possibility of reinfection and drug resistance for the men themselves.⁴

These data provide further evidence that HIV positive and negative homosexual men have both adopted HIV risk reduction strategies.^{1,2} None the less, high risk sexual behaviour (that is, non-concordant UAI) was reported. Overall, non-concordant UAI was reported by 15.8% (75) of HIV negative and 20.7% (26) of HIV positive men (*p*=0.2). No significant differences were seen when stratified by either relationship or HIV status (table 1). In the multivariate model there was no significant association between non-concordant UAI and either HIV status (*p*=0.4) or being in a relationship (*p*=0.7).

Non-concordant UAI was usually reported with a casual partner with one notable exception. HIV negative men in a relationship were equally likely to report non-concordant UAI with a main partner alone (8.0%) as with a casual partner (6.5%) highlighting the continuing risk for HIV transmission between regular partners.^{2,5} However, for most men the risk of HIV transmission occurred in the context of a casual sexual encounter. Surveys conducted in the gyms in 1998 and 1999 revealed similar patterns of sexual risk behaviour (data available from authors).

In conclusion, HIV negative and positive homosexual men have adopted different strategies for reducing the risk of HIV transmission with their sexual partners. HIV negative men predominantly reported concordant UAI with a main partner in the context of a

relationship while HIV positive men were more likely to report concordant UAI with a casual partner. HIV prevention programmes need to reinforce risk reduction strategies, tailored to a person's HIV status, while simultaneously addressing high risk sexual behaviour.⁶

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A mobile phone text message and *Trichomonas vaginalis*

EDITOR,—Over the past decade vast numbers of the general population have accepted the internet, email, and mobile phones. Among

new patients attending our centre 70.3% (90/118) of men and 73.7% (98/133) of women provide mobile telephone numbers for contact. However, the use of mobile phones as a mechanism for contact tracing as far as I am aware has not been reported previously.

A 26 year old Afro-Caribbean man presented to our clinic and informed us that his girlfriend had attended a GUM clinic but unfortunately he did not know why. However, he informed us that he had a text message on his mobile. He duly brought up the message, which gave the woman's clinic number and the KC60 diagnosis of C6A.

On examination there were no abnormalities seen, there were no polymorphs on microscopy, swabs for gonorrhoea, chlamydia, and trichomonas were all clear. He was treated with a 5 day course of metronidazole as per MSSVD guidelines.

If this patient had turned up without a contact slip, epidemiological treatment of trichomonas is unlikely to have been instituted and contact tracing would have been impossible. Thanks to the use of text messaging on this man's mobile phone, appropriate treatment was initiated. Certainly patients and health advisers appreciate the security offered by mobile phones (no other family members can take the calls), the instant access, and it avoids additional paper work. The use of text messaging and mobile phones for contact tracing may be considered as an adjunct to contact slips in GU clinics.

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Chaperoning male patients

EDITOR,—I was delighted to see the letter by Fisk *et al* in the journal.¹ My staff and I were becoming alarmed at the suggestion that male patients should have a chaperone when they are being examined by a male doctor. Was common sense finally leaving the specialty? There are thousands of consultations taking place throughout the country, in both primary and secondary care, where sexual issues are discussed. These often include a genital examination, and just because there is a problem found with one or two individual patients or doctors it doesn't mean the whole national service has to be turned upside down. Surely, the last thing an overworked, under pressure, genitourinary medicine service needs is to have another section of its skilled staff standing idly by in a room, while either a consultation or examination is taking place. I have never found any difficulty in taking the swabs on my own, and labelling the stuff myself, and have never felt the need for another person handing me things during a male examination. Indeed, I could easily see that interfering with the process at times, as there are some issues patients feel more comfortable discussing on a one to one basis, and they can feel embarrassed and hindered if there is a chaperone present.

An occasional complaint is a small price to pay for the 99.9% otherwise effective consultations that occur. It's lovely to see work like this published, as it becomes part of the evidence base that says we don't need this